PRINTED: 12/07/2011 FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

TN9008

A. BUILDING B. WING_

01 - MAIN BUILDING 01

12/05/2011

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

445 MOODLAMM DOWE

| LAKEBRIDGE HEALTH CARE CENTER 115 JO | | JOHNSOI | 15 WOODLAWN DRIVE DHNSON CITY, TN 37604 | | |
|--|---|--|--|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA | CILL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLET DATE |
| N 002 | 1200-8-6 No Deficiencies | | N 002 | | |
| | During the Life Safety portion of the survere no deficiencies cited from 1200-8-6 Standards for Nursing Homes. | vey, there 6, | | | |
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| | Ith Care Facilities | | | | |

TITLE

(X6) DATE

_ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TV9Z21

If continuation sheet 1 of 1